		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006353

Facility Name: APOSTOLIC CHRISTIAN SKYLINES

Address: 7023 NORTH EAST SKYLINE DRIVE (Number) PEORIA (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (309) 691-8091 **Fax #** (309) 683-2505

IDPA ID Number: 370716056002

Date of Initial License for Current Owners: 08/12/1966

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DAVE BLUNIER **Telephone Number:** (309) 691-8091

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER D HERMAN
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,124	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	43	Intermediate (ICF)	43	15,738	3
4	0	Intermediate/DD	0	0	4
5	29	Sheltered Care (SC)	29	10,614	5
6	0	ICF/DD 16 or Less	0	0	6
7	86	TOTALS	86	31,476	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	913	3,077	764	4,754	8
9	SNF/PED	0	0	0		9
10	ICF	3,066	12,152	0	15,218	10
11	ICF/DD	0	0	0		11
12	SC	388	6,840	0	7,228	12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	4,367	22,069	764	27,200	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.42%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
day care, outpatient therapy, housekeeping, laundry, meals, maintenance

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/12/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 764

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 1/1/04-12/31/04 Fiscal Year: 1/1/04-12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	187,983	15,344	1,969	205,296	(5,217)	200,079	(22,606)	177,473			1
2	Food Purchase		171,945		171,945	(4,444)	167,501		167,501			2
3	Housekeeping	81,288	15,713		97,001		97,001		97,001			3
4	Laundry	47,800	6,410		54,210		54,210	(3,072)	51,138			4
5	Heat and Other Utilities			100,676	100,676		100,676	(20,135)	80,541			5
6	Maintenance	92,706	33,488	18,086	144,280		144,280	(11,280)	133,000			6
7	Other (specify):*			3,297	3,297		3,297	(330)	2,967			7
8	**TOTAL General Services**	409,777	242,900	124,028	776,705	(9,661)	767,044	(57,423)	709,621			8
	B. Health Care and Programs											
9	Medical Director			338	338		338		338			9
10	Nursing and Medical Records	1,594,267	96,519	8,432	1,699,218		1,699,218		1,699,218			10
10a	Therapy	19,031		54,028	73,059		73,059		73,059			10a
11	Activities	114,644	3,002	1,490	119,136		119,136		119,136			11
12	Social Services	70,785		1,790	72,575		72,575		72,575			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,798,727	99,521	66,078	1,964,326		1,964,326		1,964,326			16
	C. General Administration											
17	Administrative	69,186			69,186		69,186		69,186			17
18	Directors Fees											18
19	Professional Services			51,289	51,289		51,289	(15,651)	35,638			19
20	Dues, Fees, Subscriptions & Promotions			8,740	8,740		8,740	(661)	8,079			20
21	Clerical & General Office Expenses	98,179	36,933	18,297	153,409		153,409	(12,139)	141,270			21
22	Employee Benefits & Payroll Taxes			619,530	619,530	9,661	629,191	(15,415)	613,776			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,717	7,717		7,717		7,717			24
25	Other Admin. Staff Transportation			1,095	1,095		1,095		1,095			25
26	Insurance-Prop.Liab.Malpractice			104,070	104,070		104,070	(10,407)	93,663			26
27	Other (specify):*											27
28	**TOTAL General Administration**	167,365	36,933	810,738	1,015,036	9,661	1,024,697	(54,273)	970,424			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,375,869	379,354	1,000,844	3,756,067		3,756,067	(111,696)	3,644,371			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES #0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			290,937	290,937		290,937	(53,392)	237,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,676	1,676		1,676	(1,676)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			292,613	292,613		292,613	(55,068)	237,545			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			162,006	162,006		162,006		162,006			39
40	Barber and Beauty Shops		57	21,547	21,604		21,604		21,604			40
41	Coffee and Gift Shops		5,622		5,622		5,622		5,622			41
42	Provider Participation Fee			31,293	31,293		31,293		31,293			42
43	Other (specify):* **Non-Care Items**	62,436		16,072	78,508		78,508	(78,508)				43
44	**TOTAL Special Cost Centers**	62,436	5,679	230,918	299,033		299,033	(78,508)	220,525			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,438,305	385,033	1,524,375	4,347,713		4,347,713	(245,272)	4,102,441			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Line 7 Explanations

Security Expense	51.75
Disposal Services	3,245.64

Line 43 Explanations

The items on this line are for expenditures related to our non-care related services, such as independent living

Reclassifications

$9,661 was reclassified from dietary costs to employee benefits for the meal discount given to employees

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(22,606)	1		4
5	Telephone, TV & Radio in Resident Rooms	(12,139)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,072)	4		8
9	Non-Straightline Depreciation	(53,392)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,676)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(133,192)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,077)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (226,077)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

APOSTOLIC CHRISTIAN SKYLINES

ID# 0006353

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Employee Benefits and Payroll Taxes	$ (15,415)	22	1
2	Non-Care Maintenance Items	(11,280)	6	2
3	Misc. Non-Care related wages and Expenditures	(78,508)	43	3
4	Non-Care Heat and Other Utilities	(20,135)	5	4
5	Non-Care Disposal and Security	(330)	7	5
6	Non-Care Insurance	(10,407)	26	6
7	Non-Care Related Legal Fees	(15,426)	19	7
8	Non-Care Related Association Dues	(661)	20	8
9	Non-Care Appraisal	(225)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(152,387)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(22,606)	0	0	0	0	0	0	0	0	0	0	(22,606)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,072)	0	0	0	0	0	0	0	0	0	0	(3,072)	4
5	Heat and Other Utilities	(20,135)	0	0	0	0	0	0	0	0	0	0	(20,135)	5
6	Maintenance	(11,280)	0	0	0	0	0	0	0	0	0	0	(11,280)	6
7	Other (specify):*	(330)	0	0	0	0	0	0	0	0	0	0	(330)	7
8	**TOTAL General Services**	(57,423)	0	0	0	0	0	0	0	0	0	0	(57,423)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,651)	0	0	0	0	0	0	0	0	0	0	(15,651)	19
20	Fees, Subscriptions & Promotions	(661)	0	0	0	0	0	0	0	0	0	0	(661)	20
21	Clerical & General Office Expenses	(12,139)	0	0	0	0	0	0	0	0	0	0	(12,139)	21
22	Employee Benefits & Payroll Taxes	(15,415)	0	0	0	0	0	0	0	0	0	0	(15,415)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(10,407)	0	0	0	0	0	0	0	0	0	0	(10,407)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(54,273)	0	0	0	0	0	0	0	0	0	0	(54,273)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,696)	0	0	0	0	0	0	0	0	0	0	(111,696)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(53,392)	0	0	0	0	0	0	0	0	0	0	(53,392)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,676)	0	0	0	0	0	0	0	0	0	0	(1,676)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(55,068)	0	0	0	0	0	0	0	0	0	0	(55,068)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(78,508)	0	0	0	0	0	0	0	0	0	0	(78,508)	43
44	**TOTAL Special Cost Centers**	(78,508)	0	0	0	0	0	0	0	0	0	0	(78,508)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(245,272)	0	0	0	0	0	0	0	0	0	0	(245,272)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Board Members of Apostolic Christian Skylines - 2004

Name	Services Provided	Entity providing service
Norbert Schneider	No Services Rendered	
David Ginzel	No Services Rendered	
Russell Rumbold	Tax Form Preperation	Gorenz & Assoc.
Richard Herman	No Services Rendered	
Robert Miller	No Services Rendered	
Larry Herman	No Services Rendered	
James Rieker	No Services Rendered	
Marvin Knobloch	No Services Rendered	
Earl Grimm	No Services Rendered	
Steven Schmidgall	No Services Rendered	

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTIAN SKYLINES COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,100 B. General Construction Type: Exterior Brick Frame Steel/Masonary Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments (assisted living) - 18,850 square feet, 12 assisted living units and 5 independent units

Duplexes - approximately 1,150 square feet per unit - 16 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	32		1966	1965	$ 348,310	$ 8,708	40	$ 8,708	$ 0	$ 273,424	4
5	36		1971	1971	396,963	9,924	40	9,924		271,920	5
6	16		1985	1985	750,000	18,750	40	18,750		303,750	6
7	3		1989	1988	205,070	5,127	40	5,127		66,648	7
8			1995	1995	870,388	21,760	40	21,760		178,430	8
	Improvement Type**										
9	17 BED ROOM ADDITION ACQUIRED IN 1996			1996	793,538	19,838	40	19,838		146,805	9
10	SHELTERED CARE REMODEL			1974	6,594	165	40	165		4,875	10
11	FIRE PREVENTION SYSTEM			1977	23,804	952	25	952		15,559	11
12	DINING ROOM ADDITION			1978	38,922	973	40	973		27,604	12
13	FIRE PREVENTION SYSTEM			1979	35,330	1,413	25	1,413		25,285	13
14	WINDOW REPLACEMENT			1981	23,820	953	25	953		16,606	14
15	KITCHEN REMODEL			1982	21,631	541	40	541		14,537	15
16	ENERGY CONSERVATION			1983	8,413	561	15	561		5,915	16
17	SHELTERED CARE REMODEL			1984	7,742	194	40	194		5,032	17
18	CABINETS			1986	1,618	108	15	108		1,079	18
19	AIR CONDITIONING			1987	6,427	643	10	643		4,410	19
20	PHYSICAL THERAPY			1989	11,503	288	40	288		6,678	20
21	OFFICE ADDITION			1991	50,297	1,257	40	1,257		27,412	21
22	NEW ROOF			1993	14,210	1,421	10	1,421		8,217	22
23	ROOM REMODEL			1994	5,154	206	25	206		2,549	23
24	FRONT ENTERANCE, FRONT OFFICE, CEILING BACK HALL			1996	62,294	3,115	20	3,115		28,032	24
25	GUTTERS, DOWNSPOUTS, FACIA - REMODEL 1971			1996	89,096	3,564	25	3,564		32,075	25
26	FENCE, FRONT SOFFIT AND FACIA, AUTO FRONT DOOR			1997	28,036	1,121	25	1,121		9,299	26
27	NEW FLOOR COVER, LIGHTS, PAINT, WALLPAPER			1998	88,061	17,612	5	17,612		40,585	27
28	DOOR AND FIRE ALARMS			2000	4,978	332	15	332		935	28
29	NEW FLOOR COVER, LIGHTS, PAINT, WALLPAPER			2000	110,832	22,166	5	22,166		35,601	29
30	NEW FLOOR COVER, LIGHTS, PAINT, WALLPAPER			2001	42,939	8,588	5	8,588		12,613	30
31	NEW WINDOWS IN LOBBY			2001	3,577	143	25	143		859	31
32	BLACKTOP PARKING LOT			2001	13,967	1,746	8	1,746		3,055	32
33	BALCONY REPAIR			2001	10,888	544	20	544		2,722	33
34	INSULATION			2001	9,970	665	15	665		1,599	34
35	LAWN SPRINKLER			2001	9,650	643	15	643		1,548	35
36	New Air Conditioner units in 1989 Addition			2001	2,178	217	10	217		390	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LOCKS	2002	$ 691	$ 35	20	$ 35	$	$ 79	37
38	NEW FLOOR COVER, PAINT, WALLPAPER, TUB	2002	14,570	728	20	728		2,810	38
39	NEW FLOOR COVER, PAINT, WALLPAPER, TRIM	2002	9,786	1,957	5	1,957		3,355	39
40	BALCONY REPAIR	2002	7,403	370	20	370		1,428	40
41	CARPET FOR DINING ROOM	2002	5,446	1,089	5	1,089		1,337	41
42	NEW HOT WATER HEATER	2002	4,197	420	10	420		647	42
43	LAWN SPRINKLER SYSTEM	2002	8,888	593	15	593		1,166	43
44	SEWER SYSTEM UPGRADE	2002	6,400	320	20	320		733	44
45	CONDENSER IN MAIN ENTERANCE	2003	1,700	85	20	85		216	45
46	SEWER SYSTEM UPGRADE	2003	6,400	320	20	320		533	46
47	COUNTERTOPS FOR SALEM	2003	6,594	440	15	440		593	47
48	CARPET FOR SALEM	2004	5,878	392	5	392		392	48
49	WIREMESH IN STARWAY	2004	1,825	122	15	122		122	49
50	SEWER SYSTEM UPGRADE	2004	7,200	270	20	270		270	50
51	TRANSFER KITCHEN AND SALEM ELECTRIC PANEL	2004	2,068	92	15	92		92	51
52	NEW 65 GAL NG WATER HEATER	2004	7,646	382	10	382		382	52
53	REWIRING FOR COMPUTER HARDWARE	2004	1,327	11	20	11		11	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65	PLEASE NOTE THAT BASED UPON A RECCOMENDATION FROM OUR ACCOUNTANT WE HAVE CHANGED LIVES ON SEVERAL ASSETS!								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,194,219	$ 161,864		$ 161,864	$ 0	$ 1,590,213	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 788,307	$ 52,554	$ 52,554	$	15	$ 315,687	71
72	Current Year Purchases	57,932	6,222	6,222		5 to 15	6,222	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 846,239	$ 58,776	$ 58,776	$		$ 321,909	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1999 Ford Bus	1999	$ 58,988	$ 14,747	$ 14,747	$	4	$ 44,242	76
77	Grounds Maintenance	2002 John Deere	2002	6,475	2,158	2,158		3	3,454	77
78	Grounds Maintenance	1979 John Deere	1979	4,400					4,400	78
79										79
80	TOTALS			$ 69,863	$ 16,905	$ 16,905	$		$ 52,096	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,111,064	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 237,545	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,545	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,964,218	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Building Assets	$ 1,470,277	$ 36,759	$ 679,346	86
87	Non-Care Equipment Assets	57,003	3,834	25,997	87
88	Non-Care Vehicle Assets	30,681	6,962	23,522	88
89					89
90					90
91	TOTALS	$ 1,557,961	$ 47,555	$ 728,865	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

All aides hired have been trained and meet requirements prior to employment

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	74	$ 4,235	$	74	$ 4,235	1
2	Licensed Speech and Language Development Therapist	10a	hrs		33	1,782		33	1,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		114	6,876		114	6,876	4
5	Physician Care		visits							5
6	Dental Care		visits			2,005			2,005	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				155,406		155,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	221	$ 14,898	$ 155,406	221	$ 170,304	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 253,285	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	422,882		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,976		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 699,143	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	380,893		12
13	Land	113,189		13
14	Buildings, at Historical Cost	5,664,495		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,003,786		16
17	Accumulated Depreciation (book methods)	(2,693,080)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,204,218		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,673,501	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,372,644	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,577	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,603		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Vacation and other Benefits Pay.	58,619		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 212,799	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingent Fund	83,132		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 83,132	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 295,931	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,076,713	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,372,644	$	48

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,124,256	1
2	Restatements (describe):	78	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,124,334	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(47,621)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (47,621)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,076,713	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,723,311	1
2	Discounts and Allowances for all Levels	(226,076)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,497,235	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	107,302	6
7	Oxygen	1,369	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 108,671	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,204	12
13	Barber and Beauty Care	21,547	13
14	Non-Patient Meals	44,777	14
15	Telephone, Television and Radio	9,971	15
16	Rental of Facility Space		16
17	Sale of Drugs	153,071	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	538	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,072	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 239,180	23
	D. Non-Operating Revenue		
24	Contributions	335,155	24
25	Interest and Other Investment Income***	106,309	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 441,464	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Related Income	13,542	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,542	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,300,092	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	776,705	31
32	Health Care	1,964,326	32
33	General Administration	1,017,919	33
	B. Capital Expense		
34	Ownership	292,613	34
	C. Ancillary Expense		
35	Special Cost Centers	264,857	35
36	Provider Participation Fee	31,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,347,713	40
41	**Income before Income Taxes (line 30 minus line 40)****	(47,621)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (47,621)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,758	2,069	$ 56,869	$ 27.49	1
2	Assistant Director of Nursing	1,892	2,069	50,919	24.61	2
3	Registered Nurses	13,850	15,267	304,597	19.95	3
4	Licensed Practical Nurses	16,426	18,141	296,387	16.34	4
5	Nurse Aides & Orderlies	69,065	74,658	862,323	11.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,368	1,490	19,031	12.77	8
9	Activity Director	3,512	3,828	43,343	11.32	9
10	Activity Assistants	7,722	8,305	71,301	8.59	10
11	Social Service Workers	1,886	2,018	31,768	15.74	11
12	Dietician					12
13	Food Service Supervisor	1,891	2,007	23,348	11.63	13
14	Head Cook	3,982	4,231	44,442	10.50	14
15	Cook Helpers/Assistants	11,592	12,427	120,193	9.67	15
16	Dishwashers					16
17	Maintenance Workers	4,170	4,597	68,169	14.83	17
18	Housekeepers	7,320	7,972	69,019	8.66	18
19	Laundry	4,650	4,946	40,789	8.25	19
20	Administrator	1,889	1,997	69,186	34.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,877	1,976	44,273	22.41	23
24	Clerical	5,298	5,593	53,906	9.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,940	2,018	39,017	19.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,301	2,467	23,172	9.39	31
32	Other Health Care(specify)					32
33	Other(specify) Dir. Of E.S.	1,822	1,872	43,817	23.41	33
34	TOTAL (lines 1 - 33)	166,211	179,948	$ 2,375,869 *	$ 13.20	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	79	$ 1,969		35
36	Medical Director	5	338		36
37	Medical Records Consultant	18	1,080		37
38	Nurse Consultant				38
39	Pharmacist Consultant	97	5,347		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,490		44
45	Social Service Consultant	45	1,790		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	$ 12,014		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roger D. Herman	Administrator	0	$ 69,186
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,186

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Westervelt, Johnson, Etc	Legal - employment issues	$ 6,185
FR&R Consulting	Medicare Consultation	422
Apostolic Christian Restmoor	Wage Survey	293
Wellspring	Innovative Solutions	18,473
P.K. Bhosale	Architectural Consultation	360
Michael Best Fried. - Non Care	Legal - Corporate	15,426
Gorenz & Assoc.	Accounting Fees	675
Lorraine G Hiatt	Strategic Plan Consultant	9,229
Roy L. Windsor - Non Care	Appraisal	225
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,289

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,449
Unemployment Compensation Insurance	5,199
FICA Taxes	182,631
Employee Health Insurance	271,199
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	3,265
Misc. Employee Incentives	28,689
401(k) Retrirement Plan	70,099
TOTAL (agree to Schedule V, line 22, col.8)	$ 619,530

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	805
Health Care Worker Background Check	731
(Indicate # of checks performed 48)	
Life Services Network	4,255
Trade Publications	1,256
Publications for Residents	654
Employer's Association	380
Misc. Dues and Subscriptions	660
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,740

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,211
In-State Travel	2,019
Seminar Expense	4,488
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,717

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number APOSTOLIC CHRISTIAN SKYLINES # 0006353 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN ($3,152.00) AAHSA ($ 1,145)**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,886** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **31,293**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,661** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,114**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes - To the AAHSA Convention**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.